Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Hepatocellular Carcinoma—Screening and Latency Period

TO THE EDITOR: I was surprised that the recent Medical Staff Conference on primary hepatocellular carcinoma[1] did not include a discussion of screening among high-risk populations. It has been known for a number of years that at a very early, resectable stage, hepatocellular carcinoma releases measurable and abnormal amounts of α-fetoprotein. A screening program based on this fact led to the early diagnosis of 134 cases of primary hepatocellular carcinoma in Shanghai in the early 1970s.[2] In our country, an active screening program among Alaskan natives by the Alaska Native Health Service in conjunction with the Centers for Disease Control has led to the early diagnosis of resectable malignancies in more than one person.[3] While the Medical Staff Conference discussed treatment of advanced carcinoma in some detail, it completely ignored such proved screening efforts, which might hold out a great deal of hope for populations in other parts of the world where the disease is endemic.

I also question the statement that the latency period is 40 years from the onset of hepatitis B carriage to the development of carcinoma. Many cases have occurred in young patients who clearly have been carriers for only a few years at most.

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Dr Tseng Replies

TO THE EDITOR: The screening of high-risk populations for hepatocellular carcinoma (HCC) does indeed offer the potential of discovering an early, resectable lesion. Dr Trotter is correct in stating that screening programs might provide hope for populations in other parts of the world where HCC is endemic. Kubo and co-workers[1] state that a continuous check of serum α-fetoprotein levels in patients with chronic liver disease is imperative in areas where HCC is frequent. However, α-fetoprotein screening, although convenient, may not be sensitive enough in detecting early HCC.[2] Ultrasonography of the liver, combined with α-fetoprotein screening, may provide a more sensitive and feasible alternative.[3] Whether such screening programs in countries where HCC is common will be cost effective and impact on long-term patient survival remains to be determined.

The association of HCC and prior exposure to hepatitis B virus is intriguing. Beasley and associates reported 116 cases of HCC in 22,707 Taiwanese men, with 113 cases among 3,454 carriers of the hepatitis B surface antigen.[4] In this study, the greatest incidence per 100,000 population occurred in patients between 50 and 70 years of age. The incidence of HCC rose with increasing age, so the risk appeared to be a function of the duration of the HBsAg carrier state. Although a prolonged latency period of 20 to 30 years has also been reported by Arthur and colleagues[5] for adult HCC, hepatitis B virus may also play a role in the development of HCC in children.[6,7] Such cases are rare and the incidence of HBsAg positive cases is much lower than in adults;[8] however, in high-risk populations, the disease does occur in younger age groups.

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AIDS—The Responsibility of Health Workers to Assume Some Degree of Personal Risk

TO THE EDITOR: Despite the plethora of published writings on medical ethical subjects that have appeared in recent years, little or no attention has been directed to the obligation or duty